TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
EMPLOYERS PREFERRED INSURANCE COMPANY

MFDR Tracking Number
M4-18-0636-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
November 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida obtained preauthorization for 6 sessions of Individual Psychotherapy on 5/31/17. Authorization... was issued for the 6 sessions with a date range of 30 days... This date of service was performed within the authorized timeframe and was denied in error... Please reprocess the attached claim and supporting documentation for payment."

Amount in Dispute: $384.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The diagnosis that were treated on the listed dates of service are not a compensable part of this workers compensation claim. On 7/08/16 the attached PLN11 was issued. On 5/25/17 a copy of the PLN11 was faxed to Neuva [sic] Vida... All payments are subject to review of the medical bill(s) by the Worker's Compensation payer or administrator..."

Response Submitted by: Employers Services, Inc.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 1, 2017, June 8, 2017 and June 12, 2017	90837 x 3	$384.00	$384.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 6532 – Absence of, or exceeds, pre-certification/authorization

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor submit documentation to support that CPT Code 90837 rendered on June 1, 2017, June 8, 2017 and June 12, 2017 were preauthorized?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT code(s) 90837 rendered on June 1, 2017, June 8, 2017 and June 12, 2017. The insurance carrier denied/reduced the disputed services with denial/reduction code(s) "6532 – Absence of, or exceeds, pre-certification/authorization."

   The insurance carrier, in the position summary states in pertinent part, "The diagnosis that were treated on the listed dates of service are not a compensable part of this workers compensation claim. On 7/08/16 the attached PLN11 was issued. On 5/25/17 a copy of the PLN11 was faxed to Neuva [sic] Vida..."

   The requestor states in pertinent part, "Nueva Vida obtained preauthorization for 6 sessions of Individual Psychotherapy on 5/31/17. Authorization... was issued for the 6 sessions with a date range of 30 days..."

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent submitted a position summary containing new denial reasons. The additional denial reasons identified on the position summary, "The diagnosis that were treated on the listed dates of service are not a compensable part of this workers compensation claim" are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits presented with the DWC060 request. The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requestor prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.

2. The requestor seeks reimbursement for CPT code(s) 90837 rendered on June 1, 2017, June 8, 2017 and June 12, 2017. The insurance carrier denied/reduced the disputed services with denial/reduction code(s) "6532 – Absence of, or exceeds, pre-certification/authorization."

   28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   The requestor submitted a copy of a preauthorization letter dated May 31, 2017 issued by PRIUM Medical Cost Management Services.

Requested Procedure/Service	Individual/psychotherapy 6 sessions over 8 weeks (CPT Codes: 90837 psytx pt & family 60 minutes).
Determination	Recommend approval
Timeframe to provide certified procedure/service	30 days (unless other specified by customer)

   The requestor rendered CPT Code 90837 on June 1, 2017, June 8, 2017 and June 12, 2017, within the preauthorized timeframes, as a result, the Division finds that the insurance carrier's denial reason is not supported and the disputed service are reviewed pursuant to the applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

28 Texas Administrative Code §134.203 states in pertinent part, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

Procedure code 90837, rendered on June 1, 2017, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 0.929 is 0.42734. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.809 is 0.08899. The sum of 3.51633 is multiplied by the division conversion factor of $57.50 for a MAR of $202.19. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $128.00. Therefore this amount is recommended.

Procedure code 90837, rendered on June 8, 2017, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 0.929 is 0.42734. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.809 is 0.08899. The sum of 3.51633 is multiplied by the division conversion factor of $57.50 for a MAR of $202.19. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $128.00. Therefore this amount is recommended.

Procedure code 90837, rendered on June 12, 2017, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 0.929 is 0.42734. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.809 is 0.08899. The sum of 3.51633 is multiplied by the division conversion factor of $57.50 for a MAR of $202.19. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $128.00. Therefore this amount is recommended.

The division finds that the requestor is therefore entitled to reimbursement in the amount of $384.00 for CPT Code 90837 rendered on June 1, 2017, June 8, 2017 and June 12, 2017.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $384.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $384.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		December 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.